# Attachment K

## Division P&P Regarding Continuity of Care (Transitions)

**ADULT MENTAL HEALTH DIVISION**

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| **POLICY AND PROCEDURE MANUAL** | **Number: 60.638** |
| AMHD Administration | Effective Date: 10/26/04<br>History: New |
| SUBJECT: Continuity of Care (Transitions) | Page: 1 of 4 |
| REFERENCE: American Association of Community Psychiatrists (AACP) Continuity of Care Guidelines; : Plan for Community Mental Health Service IV,B,1,b | APPROVED:<br><br>_____<br>Title: Chief, AMHD |

## PURPOSE

To establish standards for the transition of care between levels of care and between providers of services.

## POLICY

Adult Mental Health Division (AMHD) shall adopt the transition guidelines and outcome indicators established by the American Association of Community Psychiatrists (AACP) to assure that consumers who are moving between levels of care or between service providers are given adequate support and structure to assure a positive transition through the use of the following principles that are detailed in the AACP Continuity of Care Standards:

- Prioritization
- Comprehensiveness
- Coordination
- Continuity
- Service User Participation
- Support System Involvement
- Service User Choice
- Cultural Sensitivity

- Prevention
- Resource Utilization
- Timing
- Designation of Responsibility
- Accountability
- Special Needs
    - Addictions
    - Geriatrics
    - Forensics
    - Child and Adolescence

**DEFINITIONS**

Transition:

The movement between levels of care or between providers of services. According to AACP guidelines:

- "Transition implies concurrent and bi-directional responsibilities of all relevant elements of the service system as specific aspects of the treatment plan change.
- Transition implies collaboration among providers, which is required for a successful progression through the continuum."

Designated Case Manager:

The case manager who is designated as the primary person responsible for the development and updates of the Individualized Service Plans (ISPs).

## PROCEDURE

AMHD shall adhere to the following procedures:

1. The Level of Care for Utilization Systems (LOCUS) shall be the primary clinical tool used in determining when a change in level of care is needed. The designated case manager shall be responsible for the completion of the LOCUS.

2. Consumer involvement and choice shall guide the development of transition planning and provider selection. Transition planning shall include the consumer, the consumer's case manager, the consumer's support systems, and both the current and new provider(s).

3. The Individual Service Plan (ISP) shall incorporate transition planning and the new provider shall "incorporate relevant elements of any preexisting treatment plan" into the new ISP.

4. Transition plans that involve movement to a lower level of care shall include relapse prevention planning.

5. Transition planning shall detail specific timelines and responsibilities of all parties involved in the transition period.

6. The existing provider shall maintain responsibility for the service being provided to the consumer until the time that the consumer is adequately ready for transfer to another provider.

7. AMHD shall establish a payment schedule for transition services for the new provider at the beginning of the transition and for the old provider at the end of the transition.

8. Transition periods shall be limited and shall be based upon the individual needs of the consumer and not the convenience of any provider.

9. In cases where a consumer moves to a higher level of care due to safety or functional reasons and a transition period cannot occur, the previous provider and the new provider shall cooperate with the consumer's case manager in providing information and supports to assure a smooth transition to the higher level of care.

10. The following services and conditions constitute Transitions and require the above detailed planning to occur:

    a. Between any level of Case Management or change in Case Management provider

    b. Between Specialized Residential services and all other community services

    c. Between levels of Housing

    d. Between Day Services (Intensive Outpatient Hospital, Psychosocial Rehabilitation, Clubhouse, Day Treatment for Dual) or change in providers of these services

11. AMHD Quality Management (QM) shall include transition standards in their monitoring process based on the Outcome Indicators established by the AACP.

**ATTACHMENT**

AACP CONTINUITY OF CARE GUIDELINES

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

# AACP CONTINUITY OF CARE GUIDELINES

Best Practices for Managing Transitions Between
Levels of Care

## INTRODUCTION

Continuing engagement with treatment and recovery services is one of the most important aspects of addressing an episode of illness or ongoing disabilities associated with severe behavioral health problems. Interruption of care, for whatever reason, is among the most significant obstacles to establishing a stable recovery. It is in response to these circumstances that the AACP has prepared these guidelines to assist providers and planners in establishing standards for the management of transitions between levels of care.

### A Progressive Conceptualization of the Service Continuum

With the development of LOCUS and CALOCUS, the AACP developed a structure of variable intensity service arrays that incorporate evolving concepts of "Levels of Care". In contrast to traditional concepts, overlapping and integrated levels of resource intensity are described, more conducive to providing true linkages between the phases of treatment for a given episode of illness. It is from this perspective that we have elaborated these guidelines for transition management.

### Critique of Traditional Terminology

The traditional terminology of "discharge" planning is usually counterproductive in establishing continuity of care as it reinforces the notion of discreet, independent treatment programs operating in a fragmented system of care. Consequently, "discharge" terminology implies:

- Termination of service rather than a *transformation* of service variables and continuation of service in another setting.
- Recovery is sufficiently established and stable that services are no longer required.
- The *complete* termination of one provider's responsibility and the *equally complete* assumption of responsibility by another provider.

These concepts associated with discharge often lead to conflict between providers and the development of cracks in the service continuum through which many consumers readily fall.

### Transition Rather Than Discharge

"Transition" planning better captures the concept of continuing care (not aftercare) throughout the episode of illness or service need.

- Transition implies concurrent and bi-directional responsibilities of all relevant elements of the service system as specific aspects of the treatment plan change.

- Transition implies collaboration among providers, which is required for a successful progression through the continuum.

Although this concept of fully integrated service systems still remains idealistic in most cases, the articulation of this ideal is an important element in the reform process. In this document we will use the traditional terminology in parallel with the more progressive "transition" terminology described here, recognizing that reality and idealism must rub shoulders during the process of change.

Applications of the Guidelines

These guidelines are intended to be more than a simple statement of principles. Rather, they are intended to provide a quality management framework by which systems of any type can continuously monitor and improve their processes for managing client transitions. For this to occur, it is essential that these organizations not only endorse these principles in theory, but also create methods to measure their implementation in practice. With this thought in mind, a sample outcome indicator is attached to each of the principles elaborated in the guidelines. Indicators of this type, customized and quantified to reflect the specific circumstances of the organization developing them, would allow for the measurement of the adherence to these principles.

These guidelines, along with their companion documents for special populations, will continue to evolve. We hope that these guidelines will be useful in their present form to all elements of the service system.

- Governmental agencies and other purchasers can use them for developing standards for contracts.

- Regulatory agencies can use them in practice guidelines and standard development.

- Program managers and quality managers can use them for developing program standards and quality indicators.

- Clinicians can use them in elaborating transition plans.

Continuity of Care Guidelines for Behavioral Health Service Systems

The following are general principles for developing transition plans for persons using behavioral health services moving from one level of care to another. They offer a synopsis of elements common to this process regardless of the setting or the population that is being served. Specific needs and issues related to special populations are elaborated in a series of companion documents, which will only be summarized here. Continuity of Care Guidelines can only offer a framework to facilitate transitions and plans which incorporate them must be adapted for each individual. They may provide a template for developing standards regarding transitions in specific circumstances throughout a service system.

Implementation of any set of guidelines is subject to the availability of resources. Community resources should be conceived of as an array of services and mutual supports which will operate as a unified system of care. If community resources are limited, the transition plan should make the most effective use of the resources that are available and reflect the most important priorities for the patient in question. Realistic determinations should be made on a case-by-case basis. Ideally, transitions between levels of care will be based on clear criteria such as those contained in the AACP's LOCUS or ASAM's PPC2. Only with an integrated, client driven, community based system of care will the ideal planning for level of care transitions be achieved.

Principles for Transition of Care Between Levels of Service

1. Prioritization: Transition or discharge planning should begin at the time of admission to any level of care and should be a part of the treatment plan. Identification of transition needs and the coordination of services required to meet them will be most urgent at the most intense levels of care.

   *Outcome Indicator:* Treatment plans, assessments and progress documentation will demonstrate activities relevant to issues likely to be encountered in anticipated transitions in treatment setting or providers.

2. Comprehensiveness: Transition plans should include all aspects of an individual's service needs. These would typically include continuing treatment, supportive services such as case management or child care, residential stabilization, treatment of co-morbid health issues, realistic financial supports, and mutual support networking. In some cases interface with the legal system or child protection/family service agencies will be required.

   *Outcome Indicator:* All aspects of a service user's needs, as identified in completed assessments, will be adequately addressed in the transition plan.

3. Coordination: Coordination of and collaboration between elements of the service system which are involved with the client on either side of the transition should occur as part of the treatment plan such that a sense of continuity is achieved while the transition evolves. Whenever possible, information regarding the most recent experience should be provided to the agency where the client will be continuing care. Appropriate incentives for providers are an essential consideration in efforts to achieve this objective.

   *Outcome Indicator:* Significant communication and coordination between all involved service providers is evident through service user's experience and relevant documentation.

4. Continuity: Transitions, either upward or downward in the continuum of services, should incorporate relevant elements of any preexisting treatment plan. Treatment plans should be relevant to the entire course of an episode of illness/disability so that they can provide a degree of continuity in the context of change if properly elaborated and utilized.

   *Outcome Indicator:* Treatment plans incorporate significant aspects of previous treatment plans and build on prior treatment initiatives.

5. Service User Participation: Extensive participation of the service user in the formulation of transition planning is critical to success. Efforts should be made to elicit the service user's perspective on the specific difficulties they anticipate in making the transition and their preferences for services, and to address these issues in the elaboration of the plan.

   *Outcome Indicator:* Documentation of the service user's perspective on the transition and his or her preferences for services is available.

6. Support System Involvement: Client and family involvement in the elaboration of the discharge/transition plan is essential from the time of admission at any level of care. The degree of family involvement will generally be dictated by the client's and the family's willingness to engage in the process. Other persons providing support in the community should be included as well if a client indicates a desire for their participation.

   *Outcome Indicator:* Significant members of the service user's support system are consulted in the formulation of the transition plan or an effort to obtain their participation is evident.

7. Service User Choice: Transition/Discharge plans must reflect reality and address client needs in the most practical way possible. This will require recognition of the phase of illness and/or recovery of the client for which services are being planned. In many cases, clients may choose to leave treatment early or they may have had marginal investment in the service they are departing from. Regardless of the circumstances of their departure or the likelihood of their continuing in treatment, a comprehensive plan should be elaborated in a manner that is as inclusive of client wishes as possible.

   *Outcome Indicator:* Service users will be offered comprehensive attention to their transition needs even when their choices do not coincide the service provider's.

8. Cultural Sensitivity: Transitions should be managed in a culturally sensitive manner. Considering this in its broadest sense, an individual's beliefs, customs, and social context must be considered when making transitions upward (to more intensive levels of service) or downward (to less intensive levels of service).

   *Outcome Indicator:* Cultural issues relevant to the transition of services are identified and adequately addressed in the transition plan.

9. Prevention: Discharge planning from highly structured settings to loosely structured settings should include comprehensive relapse prevention planning. Strategies to avoid re-initiating old, dysfunctional patterns of behavior should be identified, as well as available community supports and treatment programming. Financial supports should be arranged in such a manner as to avoid undue potential to misuse funds in detrimental ways.

   *Outcome Indicator:* Factors contributing to exacerbation of illness or disability have been identified and transition plan has included attention to strategies to minimize their impact.

10. Resource Utilization: The transition/discharge plan should be designed to maximize the resources available to the client for continuing care. This includes efforts to secure benefits for which the client is eligible with the active participation of the client. Planning should foster self-reliance while recognizing that significant support may be required in the early stages of recovery.

    *Outcome Indicator:* Resources necessary for the support of the service user in the transition environment are identified and arrangements have been completed to meet those needs.

11. Timing: Whenever possible, transitions should take place gradually, titrated according to an individual's ability to adapt to changing roles and expectations.

    *Outcome Indicator:* Opportunities to experience transition situations partially prior to termination of referring entities involvement are available and used.

12. Designation of Responsibility: Systems should develop clear protocols delineating responsibility for care of clients in transition periods. In most cases responsibilities should incorporate redundancies between the referring and receiving entities. These concurrent responsibilities will be more likely to ensure a smooth transition and prevent some of the discontinuations commonly observed in systems that do not contain overlaps between levels of care. Reimbursement arrangements should incentivize processes that incorporate concurrent responsibilities where appropriate, for the following transition functions:

    - Assuring the service user's awareness of location, time, and contact person for next scheduled treatment session.

- Assuring that the service user has access to prescribed medication and that a sufficient quantity is available to allow uninterrupted use between physician contacts.

- Assuring that the service user is aware of the person(s) to contact should there be any difficulties with either obtaining or using medication during the transition period or with any other aspects of required services.

- Assuring that the service user can identify contact persons for arranging alterations in the original discharge plan should such changes become necessary.

- Assuring that the service user is aware of the tracking plan and the process that will be initiated to re-engage him/her should unplanned alterations in the plan occur.

Outcome Indicator: *Contacts during transition period are clearly identified and service user was well informed and able to use specified arrangements.*

13. Accountability: A mechanism for monitoring outcomes of transition plans and identifying opportunities to improve the process should be in place.

- Appropriate quality indicators should be established with realistic benchmarks that can be easily measured.

- A mechanism for establishing corrective action plans for systems unable to meet those expectations should be elaborated.

- Documentation should clearly indicate that all responsibilities delineated above occur and that they do so within appropriate time frames.

- Oversight of the quality management process should include all stakeholders in the system, including persons in recovery.

- Standards established should be incorporated into contracts with Managed Care Organizations to assure proper incentives in reimbursement.

*Outcome Indicator*: A quality improvement process is in place and is comprehensive.

14. Special Needs: Recognition of the needs of special populations and their incorporation into the transition plan is an essential element of the process. Specific guidelines have been elaborated for each of the populations considered below. The following points regarding transition planning for these populations are brief summaries of some of the unique aspects of this process for these people.

Addictions:

- Confrontation of disparities between a substance user's wishes and his/her needs to maintain abstinence are critical. The distinction between engagement and enabling is frequently a fine one, and transition efforts must attempt to maximize the former while attempting to minimize the latter.

- Recognizing that co-occurring psychiatric and medical problems are expected to be present in this population, transition plans should be particularly vigilant in assuring that identified needs are met.

- Plans should emphasize fluidity in the treatment continuum and acknowledge the continuing availability of services at any required level of care should the initial transition attempt be unsuccessful. Awareness of an individual's readiness for change will guide the types of transitions that might be recommended.

- Confidentiality is given particular emphasis in this population due to the stigma associated with it. Careful consideration must be given to the transfer of information between substance use treatment providers and must be done with the full consent and knowledge of the service user.

- Family members are often involved in the dynamic that contributes to the maintenance of addictions and therefore their participation in the transition plan and continuing treatment is a critical priority whenever it is possible.

- Mutual support programs, such as the twelve steps, have traditionally been an important component of the recovery process and have played a crucial role in relapse prevention plans. Transition plans should always attempt to acknowledge and incorporate the tradition of mutual support, while emphasizing the rationale for concurrent treatment.

Geriatrics:

- Involvement of the support system is an essential aspect of care. A primary caregiver should be identified and supported to the greatest extent possible by other service providers. Early establishment of this person as one who can make decisions in cases where the service user is unable to make informed choices is essential.

- The service user's participation in transition planning with vary according to cognitive capacities, but efforts must be made to assure that the elderly person is not assumed to have limited capacity when this is not so, and that their ability to make self determined choices are maximized by clear communication and cognitively appropriate education.

- Interface with providers of physical health care is particularly important for the elderly. It must be established early and attention to these needs must be well integrated in the transition plan.

- Assessment of needs in all spheres of function must be obtained in order to insure a comprehensive transition plan. Multi-agency cooperation and communication will often be necessary to meet multiple needs.

- Insurance status may be a significant issue for many elderly clients, particularly with regard to prescription medication, as Medicare does not currently have provisions to cover these expenses.

Forensic:

- Post release planning may be avoided altogether if efforts to divert persons with mental illness from incarceration are successful.

- Post release planning cannot occur if persons with mental illness and substance use problems are not identified and engaged in treatment during the period of their incarceration.

- Residential components of the plan will be of particular importance, particularly for those persons who are homeless. This part of the plan may well be the difference between recidivism and successful community adjustment, and liaisons with community based housing resources are essential.

- Establishment or resumption of health insurance benefits will be a critical element in the post release plan.

- Interface with probation and parole supervision is vital to reducing repetition of illegal behaviors in the future.

- Facilitation of transitions may be enhanced through opportunities for inmates to meet with community providers prior to release. This is more difficult in a highly secured setting, but developing this capacity can have significant benefits with regard to service use.

Child and Adolescent:

- Multi-agency involvement in the provision of C&A Services require mutual engagement throughout periods of treatment.

- Parental responsibility or guardianship/custody must be established as quickly as possible in the course of treatment, and those who will be responsible must be involved actively in the planning process. Extended family should be included as well, unless specifically prohibited.

- Developmental level and capabilities will determine the extent of the child's participation in the planning process, but efforts should be made to maximize their role.

- Families or other responsible parties will be responsible for engagement of the child with the receiving agencies, and it will be critical to address their concerns as well as allowing for opportunities for them to interface with community providers prior to transition.

- Integration of treatment needs and educational needs should be an important aspect of transition planning and schools and teachers must be part of the planning process.

- Transitions from adolescent to adult systems of care are particularly difficult and will require special vigilance and coordination to be successfully completed. Gradual, titrated transitions will usually be required.

# Attachment L

## Division P&P Regarding Recovery (Treatment) Planning

ADULT MENTAL HEALTH DIVISION

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|---|---|
| **POLICY AND PROCEDURE MANUAL** | **Number: 60.648** |
| AMHD Administration | Effective Date: 06/03/05<br>History: New |
| SUBJECT: Recovery (Treatment) Planning | Page: 1 of 7 |
| REFERENCE: CMS; State Licensure Requirements; Plan for Community Mental Health Services | APPROVED:<br>_____/s/_____<br>Title: Chief, AMHD |

## PURPOSE

To ensure that the recovery (treatment) planning process and documentation meet recognized professional standards and result in effective, person-centered, individualized, collaborative and coordinated care of the consumer.

## POLICY

An initial recovery (treatment) plan is developed for each consumer within 72 hours of admission to an AMHD funded service. An individualized Recovery Plan, consistent with the consumer's goals and preferences is developed by an interdisciplinary team of professional staff within 30 days of admission. The Recovery Plan contains the following elements: a case formulation; statements describing the nature of the specific problems and needs of the consumer; the consumer's strengths and treatment preferences, clear, objective, behaviorally written goals with time frames for completion; a comprehensive program of treatment that includes individualized, specific treatment interventions. The consumer's recovery plan is formally re-evaluated at least every 6 months. The plan is revised as appropriate to reflect the consumer's current status, progress and treatment needs. It is then implemented according to the revisions. Progress notes shall be documented in the clinical record and shall describe the consumer's progress toward achievement of his/her goals, interventions provided, and their results.

## RESPONSIBILITY STATEMENT:

- The psychiatrist shall be in charge of the treatment team and has the ultimate authority for all clinical decisions.
- The AMHD designated case manager shall be responsible for coordinating the development and monitoring of the implementation of the Recovery Plan.

- All members of the interdisciplinary team come prepared to the meeting and collaborate with the consumer to formulate the case, plan for recovery and follow through on treatment interventions. Ideally, meetings should be face-to-face with all participants. If exceptions need to be made, the consumer must be fully informed and involved.
- The consumer is the focal point of the interdisciplinary treatment process. The consumer's role and responsibilities are delineated in the Recovery Guide.
- The psychiatrist shall ensure that the Recovery Plan is the result of collaboration between the consumer's own expressed goals for recovery and the interdisciplinary team's perspective. The Recovery Plan fully directs and integrates all care and treatment.
- The psychiatrist shall ensure that the consumer and all the disciplines are involved in the recovery planning process as directed by each consumer's needs.
- The psychiatrist is responsible and accountable for ensuring that the recovery plan is implemented.
- The psychiatrist may delegate some responsibilities to other team members.
- The psychiatrist shall ensure that performance improvement findings are used to improve recovery planning.

## PROCEDURE

### A. INITIAL RECOVERY (TREATMENT) PLAN

The Initial Recovery Plan is developed by a mental health professional within 72 hours of admission to an AMHD funded service. It is used to direct the consumer's care until the individualized Recovery Plan is developed. The focus of the Initial Recovery Plan is to meet the consumer's immediate health and safety needs.

### B. COMPOSITION OF THE TREATMENT TEAM

1. The treatment team shall, at a minimum, consist of the consumer, the psychiatrist, and the case manager.

2. The consumer is considered an essential member of the treatment team and shall be present at his or her treatment team meetings and be encouraged to participate actively.

3. Family/significant others shall be invited with the consent of the consumer and encouraged to participate in the recovery plan review meetings or have input into recovery planning.

## C. RECOVERY PLANNING PROCESS

1. Interdisciplinary planning is based on multiple mental health professionals' assessments, is consumer focused and culturally informed, and incorporates the consumer's strengths and recovery goals and preferences.

2. The planning process identifies and describes the consumer's strengths and goals, behavioral problems and needs, and prioritizes problem areas. It establishes measurable long/intermediate and short term goals as appropriate, identifies approaches or interventions based on identified strengths and facilitates consumer's meeting those goals. The Recovery Plan review evaluates the consumer's progress toward those goals on identified target dates throughout the course of care.

3. The consumer's medical/dental problems are identified and significant medical/dental problems are included in the Recovery Plan in coordination with primary care services.

4. The process involves periodic review and/or revision of the Recovery Plan to reflect the consumer's progress and current treatment needs.

5. Review of each consumer's Recovery Plan shall occur at least once every 6 months, or whenever there is a significant change in it (e.g. change in problem identification, focus of treatment, level of care, services provided), and are structured to maximize consumer, family and community involvement.

6. Recovery plans are written and modified based on the consumer's identified goals and needs.

7. New problems and associated goals are documented in the progress notes and evaluated for possible inclusion in the Recovery Plan.

8. For each consumer, timely progress notes are written by all mental health professionals involved in the consumer's care.

9. The consumer signs off on the Recovery Plan and is given an initial copy and a copy every time the Plan is updated.

## D. CONTENT OF THE RECOVERY PLAN

The Recovery Plan consists of various components, including, but not limited to those described below.

1. Recovery Plan: The Recovery Plan includes

    a. Case Formulation: The case formulation is the synthesis of assessment formation and consumer goals illustrating the interactions of specific areas in need of attention. As this understanding evolves the formulation changes. The formulation drives the Recovery Plan and includes:
        i. Is based on the domains of the LOCUS (Risk of harm; Functional Status; Medical, Addictive and Psychiatric Co-Morbidity; Recovery Environment (Level of Stress and Level of Support); Treatment and Recovery History; and Engagement)
        ii. Includes a summary of the interrelationship and prioritization of LOCUS domains for recovery, and is based on the results of multidisciplinary mental health professionals' assessment.

    b. Legal Status: This indicates the consumer's legal status on admission and is updated to reflect court actions over the course of treatment.

    c. Diagnosis: The multi-axial diagnoses (I - V) are documented on the Recovery Plan. Provisional or deferred diagnoses are to be eliminated within 30 days.

    d. Contain at least the following elements:
        i. All of the written explanations for each identified need that is not addressed in the Recovery Plan;
        ii. A written quote by the consumer describing what he or she considers to be the measure of success;
        iii. A case formulation that results from the multidisciplinary assessments used in developing the Recovery Plan;
        iv. Written treatment goals that are prioritized based on the consumer's preferences, strengths and needs;
        v. Goals that are worded in behavioral terms, with a completion time frame for each goal;
        vi. Identification of specific treatment and PSR services and other community supports to be provided to the consumer, including the amount, duration and scope;

vii. Designation of the person responsible for each intervention of the Recovery Plan;
viii. Crisis planning that shall include the preferences of the consumer and detail the steps to be taken if a crisis occurs; and
ix. Written criteria for discharge from one level of care to another as appropriate.

e. Be reviewed and updated at least once every six months or whenever there is a significant change in treatment; and

f. Comply with requirements of the service provider's accrediting body, and/or Centers for Medicare and Medicaid Services.

2. Problems, Goals, Objectives and Interventions:

a. Problem/needs title is brief, but descriptive.
i. The statement describes the nature of the specific problems and needs of the consumer.
ii. The individualized statement is meaningful to the consumer and reflects his/her goals and treatment contract with the treatment team.
iii. The initial date is included when the problem is identified (and, when applicable, the date the problem is resolved).

b. For each problem, at least one long-term goal is identified. This is objective, behaviorally worded and is framed in the consumer's own words or in words the consumer can understand.

c. A statement of consumer strengths related to the long-term goal.

d. At least one clear, objective, behaviorally worded short-term goals.
i. Each short-term goal is measurable and includes the time frame for completion.
ii. Key indicators are used to define how the consumer's progress is measured.

e. At least one specific treatment intervention for each short term goal.
i. All interventions described in the Recovery Plan shall be directed toward improving the consumer's level of function, and successful community integration.
ii. A brief statement and rationale for each intervention designed to achieve the specified short- and long-term goals specified in the plan.

iii. Start date, frequency, duration, and the name of the clinician(s) providing the intervention(s) are documented for all interventions on the Recovery Plan.

3. The individual Recovery Plan includes other elements:

   Behavior Management Plans ("BMP"), when present, are to be an integral part of the Recovery Plan and are integrated into the overall Recovery Plan. They are developed by the treatment team for identified behavioral problems.

## E. RECOVERY PLAN REVIEW (RPR)

1. Recovery Plan Review meetings are scheduled and convened by the consumer's Treatment Team 30 days after the initial recovery plan is written and at least every 6 months thereafter. When there is a change of case manager, the case manager will review the current Recovery Plan at the first session with the client. If changes are needed, minor changes can be noted on the current plan.
    a. Additional team meetings are also held to evaluate changes in behavior, e.g. levels of care and services provided.
    b. If the consumer is frequently or consistently refusing treatment and/or groups/classes, the team updates/changes the Recovery Plan. The team establishes a plan to deal with the refusals and considers offering alternate interventions including a BMP.
    c. Recovery Plan should be reviewed and revised in accordance with the attached Clinical Alert #2005-01.

2. At the Recovery Plan Review, the team, including the consumer, considers and evaluates the consumer's progress toward each goal.
    a. The Recovery Plan Review form is used to document review and updating of key information and is used to document specific changes to interventions or goals that are made to the Recovery Plan as necessary.
    b. At a minimum, this review includes as needed:
        i. A review and update of the case formulation
        ii. A review of each problem, noting response to treatment, data supporting the change(s), and making necessary adjustments to the goals and interventions. (Note: Where a consumer appears to be meeting goals, the goals should be considered for change and where there has been no progress, goals and interventions should be considered for change.)

3. The treatment team psychiatrist, consumer, community case manager, and family member(s), (if present), also sign and date the Recovery Plan Review form.

## F. DOCUMENTATION OF THE RECOVERY PLAN

1. Case management service provider and community mental health clinic maintain a paper record. After each recovery planning meeting, the appropriate forms are updated, signed and made part of the clinical record. The AMHD designated case manager shall be responsible for coordinating the development and monitoring the implementation of the Recovery Plan.

2. Recovery Plans must remain fully intact as verified by the participants' signatures. When any significant element of the Recovery Plan is revised, the whole Recovery Plan must be reprinted with the dates when the Recovery Plan was first developed and the date when the Recovery Plan was updated/changed. Only small changes to the Recovery Plan are allowed in handwriting if individually dated and signed by the person making the change.

**ATTACHMENTS:**

1) CMHC Recovery Plan
2) Clinical Alert #2005-01

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__
Initials: [_____] [_____] [_____] [_____]

Department of Health
Adult Mental Health Division

# CLINICAL ALERT

## 2005-01

May 31, 2005

Subject: Triggers for Revision of Recovery (Treatment) Plan
Timeframe: Immediate implementation

AMHD is releasing this Clinical Alert to advise providers that a formal treatment team meeting, including the consumer and resulting in written revisions to the recovery plan, is necessary whenever there is a significant change in any part of the consumer's life which may increase the risk of destabilization.

Some of these triggering situations are:

- Suicide attempt;
- ER visit or hospitalization (medical or psychiatric);
- Significant clinical change;
- Homeless or immediate risk of losing housing;
- At risk of revocation of Conditional Release order;
- Loss of a significant member of the consumer's support system, including family, friend, pet, peer support, or staff;
- Decreased or no treatment participation, including dropping out or becoming lost to follow-up; and
- Substance abuse relapse.

The above is an incomplete list. There are other situations unique to each consumer that should also be considered a trigger for a recovery plan revision. Whenever a trigger situation is identified, the consumer and treatment team should meet as soon as possible.

Background: AMHD and providers have completed a quality improvement review process around the cluster of sentinel suicide events that occurred in March and April 2005. During this review, the issue of recovery plans not being reviewed and revised immediately following significant clinical events was identified as a contributory factor to these sentinel events. This addition of triggering events for recovery plan revision will be incorporated into the impending AMHD's policy on Recovery (Treatment) Planning.

Contact: Kathy Yoshitomi
Treatment Service Director
733-4489

Thank you for your assistance in improving the quality of our services.

Sincerely,

/s/
THOMAS W. HESTER, M.D.
Chief, Adult Mental Health Division

# **Recovery Plan** – v.1b

(INDIVIDUAL SERVICE PLAN) Adult Mental Health Division

For Site Specific Use:

| Last Name: | Gender: ☐M ☐F ☐Other | Service Plan Date: | |
|---|---|---|---|
| First Name: | CR#: Tracking#: | Review Due: | |
| Case Manager: | | Review Done: | |
| Psychiatrist/Psychologist/APRN | | 2nd Review Due: | |

| STRENGTHS/PREFERENCES/CULTURAL Issues | CONSUMER LONG TERM RECOVERY OR DISCHARGE GOALS: |
|---|---|
| | |
| | |
| | |
| | |
| | |

Case formulation can be found in ☐ Psychiatrist's Intake Report in record ☐ Attached ☐ Other:

| Diagnoses | NEEDS IDENTIFIED BY CONSUMER: |
|---|---|
| Axis I: a | 1. |
| b | 2. |
| c | 3. |
| d | 4. |
| Axis II: | Criteria For Change in Level of Care: |
| Axis III: | |
| Axis IV: | |
| Axis V: (GAF) | |
| LOCUS: ☐CC ☐TCM ☐ICM ☐ACT ☐CSM | |
| GAF at review: / LOCUS at review: | |

Special Needs Considerations for Service Planning:

☐ Developmentally Disabled
☐ Transportation
☐ Non-ambulatory
☐ Needs Interpreter
☐ Hearing Impaired
☐ Limited Sight
☐ No special needs
☐ Other:

Forensic Status: (*check one)*
☐ Voluntary ☐ Parole ☐ Conditional Release
☐ Probation ☐ Supervised Release ☐ Jail Diversion Participant

Probation/Parole Officer Name:

Phone:

| ☐ History of Violence | ☐ MI/SA Stage of change: | ☐ HCR 20: | ☐ Advance Directive: |
|---|---|---|---|

**CRISIS PLAN:**
What are the consumer's triggers and warning signs?

Actions consumer/staff will take to prevent crisis: (Include names/numbers of supporters/resources)

| Actions | Person Responsible | Contact Information |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

Actions consumer/staff will take to manage crisis: (Include consumer's preferred treatments/facilities and those to avoid)

| Actions | Person Responsible | Contact Information |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

| GOAL<br>(Number to correspond with needs) | PLAN<br>(Interventions including frequency, duration and person & discipline responsible. Include referrals here.) | STATUS<br>(See key at bottom of page) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| Explanation for identified consumer needs/goals that are not addressed in the ISP: | | |

| | | | |
|---|---|---|---|
| Consumer: | Date: | Psychologist/ APRN: | Date: |
| Psychiatrist: | Date: | Legal Guardian: | Date: |
| Case Manager: | Date: | Other: | Date: |

Status Key:
OM = Outcome Met  If outcome not met, choose one:
W = Worse  NC = No Change  I = Improvement  DC = Discontinued

# Attachment M

## Definitions for Case Management Specialist

# Case Management Specialist

## Definition

A Case Management Specialist may:

- Provide all direct treatment services to consumers that do not require a licensed qualified mental health professional,
- Provide specialized services in conjunction with other professionals,
- Coordinate services,
- Make referrals,
- Develop treatment plans,
- Monitor and evaluate progress,
- Provide ongoing support,
- Provide intake and assessments, and
- Make changes to treatment plans.

## Educational and Experience Requirement

Case Management Specialists shall meet the following minimum requirements:

A Bachelor's degree with a minimum of twelve (12) semester credit hours in courses such as counseling, criminal justice, human services, psychology, social work, social welfare, sociology, or other behavioral sciences and one and one-half (1 ½) years of specialized experience.

An exception may be made for the above-mentioned educational requirement, on an individual case-by-case basis, if a candidate meets the following combination of required minimum education and experience:

**1. Education**

High School diploma or GED, plus Certification as a Substance Abuse Counselor (CSAC)

**OR**

High School diploma or GED, plus either (a) at least twelve (12) earned college credit hours in human/social services subject or (b) at least 40 hours of continuing education in human/social services subjects. The continuing education may consist of seminars, conferences, adult education courses, certification coursework, employer training, or similar educational activities.

**2. Experience**

The equivalent of two (2) years full-time work experience providing direct behavioral health services to Severe and Persistently Mentally Ill (SPMI) consumers and demonstrated working knowledge of the cultural norms, values and issues related to cultural diversity in Hawaii and demonstrated working knowledge of the health/human services system and community resources in Hawaii.

**3. References**

Three (3) verified, professional references attesting to the individual's skills, ability, and competency to meet the position duties and responsibilities of a Mental Health Specialist.

**Definition of Experience**

Specialized experience is progressively responsible professional work experience that involved helping individuals and their families find satisfactory ways of identifying their problems, coping with their conditions, and functioning effectively within their environments. This experience may include identification and evaluation of the consumer's problems and needs, the development of a service or treatment plan, the initiation and implementation of the treatment plan monitoring of services, and evaluation/assessment of the consumer's progress.

**Supervision**

Case Management Specialists who meet the minimum education requirement of a Bachelor's degree and one and a half years of experience, as specified above, shall receive clinical supervision from the team leader who is a QMHP or MHP.

Case Management Specialists with a High School diploma or GED and the additional education and experience qualifications, as specified in the exception above, shall be subject to additional clinical supervision and staff ratio requirements as follows:

1. Direct clinical supervision must be provided by a Qualified Mental Health Professional (QMHP).

2. Clinical supervision with the QMHP will occur, at minimum, in weekly, individual sessions.

3. In addition to weekly clinical supervision, a side-by-side observation session with the Team Leader or RN, in which the Team Leader/RN accompanies the Case Management Specialist to meet with a consumer, will be required at least once per month. Observations will rotate through the Case Management Specialist's caseload so that the Team Leader/RN will observe the Case Management Specialist with each consumer on their caseload over time.

4. All recovery plans and clinical record notes of the Case Management Specialist will be co-signed by the QMHP.

5. Each Case Management Specialist who meets the education requirement with a High School diploma/GED will count as two (2) FTE Bachelor's level or higher Mental Health Specialist for the purposes of determining the number of Case Management Specialists each Team Leader may supervise. In other words, the number of Case Management Specialists that a Team Leader may supervise must be reduced by one case manager for every Case Management Specialist with a High School diploma/GED on the Team Leader's team. This requirement is intended to ensure that Team Leaders have sufficient time to conduct the additional clinical supervision/observation and record review that will be necessary when working with Case Management Specialist with a High School Diploma/GED.

   Example: If a typical team size is ten (10) case managers per Team Lead, the organization must reduce the team size to nine (9) case managers if one of the case managers meets the education requirement with a High School diploma/GED (8 Bachelor's level or higher Case Managers plus 1 High School Diploma/GED Case Manager), to eight (8) case managers if two of the case managers have High School diploma/GED (6 Bachelor's level or higher Case Managers plus 2 High School diploma/GED Case Managers), etc.

6. At any given time, at least 75% of the total number of case managers employed by or contracted by an organization to serve AMHD consumers must be at least Bachelor's degreed individuals with at least one and a half years of experience. AMHD will consider granting an exception to the 75% rule, on a case-by-case basis, to providers primarily serving geographic areas with a proven shortage of qualified Bachelor's degreed and experienced case managers. Applicants must submit documentation demonstrating their efforts to recruit, hire, and retain sufficient numbers of Bachelor's degreed and experienced case managers, the number of open positions and length of time positions have remained open, and any other documentation that may demonstrate a shortage of qualified individuals in the geographic area served by the provider in order to be considered for an exception.

7. The individual consumer caseload of the Team Leader shall be reduced by 25% for each Case Manager they supervise who meets the minimum education requirement with a High School diploma.

# Attachment N

# Certifications

# CERTIFICATIONS

## 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

## 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

## 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

## 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

## 5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

| SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL | TITLE |
|---|---|
| APPLICANT ORGANIZATION | DATE SUBMITTED |

# Attachment O

## Form SPO-H-205A
## Instructions

## Instructions for Completing

### FORM SPO-H-205A
### ORGANIZATION - WIDE BUDGET
### BY SOURCE OF FUNDS

| | |
|---|---|
| **Applicant/Provider:** | Enter the Applicant's legal name. |
| **RFP#:** | Enter the Request For Proposal (RFP) identifying number of this service activity. |
| **For all columns**<br><br>**(a) thru (d)** | Report your total organization-wide budget for this fiscal year by **source of funds**. Your organization's budget should reflect the total budget of the "organization" legally named. Report each source of fund in separate columns, by budget line item.<br><br>For the first column on the first page of this form, use the column heading, "Organization Total".<br><br>For the remaining columns you may use column headings such as: Federal, State, Funds Raised, Program Income, etc. If additional columns are needed, use additional copies of this form. |
| **Columns (b), (c) & (d)** | Identify sources of funding in space provided for column titles. |
| **TOTAL (A+B+C+D)** | Sum the subtotals for Budget Categories A, B, C and D, for columns (a) through (d). |
| **SOURCE OF FUNDING:**<br><br>**(a)**<br><br>**(b)**<br><br>**(c)**<br><br>**(d)** | Identify all sources of funding to be used by your organization. |
| **TOTAL REVENUE** | Enter the sum of all revenue sources cited above. |
| **Budget Prepared by:** | Type or print the name of the person who prepared the budget request and their telephone number. If there are any questions or comments, this person will be contacted for further information and clarification.<br><br>Provide signature of Applicant's authorized representative, and date of approval. |

Special Instructions by the State Purchasing Agency:

***Provide a budget by source of funds for this specific service activity.***

# Attachment P

## Questions and Answers to RFP HTH 420-5-06

**Responses to Question Raised by Applicants For RFP No. HTH 420-5-06**
**Community-Based Case Management**

**1. Question:**

Can we propose for less than 300 clients? Or partial team?

**Answer:**

Yes. Partial teams may also be proposed.

**2. Question:**

What rate/code do the RN & peer specialist bill under (as required on pg 2-26, #4 – yet not listed on rate sheet)?

**Answer:**

There are no billable codes for the peer specialist. The DIVISION intends to amend this RFP at a later date to establish billing codes for peer specialists. The RN may bill for therapeutic injections. RNs who meet the minimum requirements for a case manager may also bill under case management codes if functioning as a case manager.

**3. Question:**

Is Community-Based CM qualified under MRO same as ICM (since ICM is a very different service)?

**Answer:**

This service replaces TCM and ICM and is an MRO service.

**4. Question:**

Why are psychologists excluded from team?

**Answer:**

Psychologists are not required to be members of the case management team. However, a psychologist may be a part of the case management team in a position for which they meet the personnel requirements identified in this RFP.

**5. Question:**

Are Hilo & Kona seen as separate areas or are they both just Hawaii?

**Answer:**

If you are submitting a proposal for services on the Big Island, the specific geographic areas that you propose to serve on the island should be identified.

**6. Question:**

Could Peer Specialists have MRO status as paraprofessionals for billing purposes? Doesn't AMHD have a Mental Health Worker category already that has MRO approval?

**Answer:**

The State Plan Amendment does not include Peer Specialists as an MRO reimbursable service. The DIVISION intends to amend this RFP at a later date to establish billing codes for peer specialists. (See Question 4, above.). The Mental Health Worker is defined by the DIVISION.

**7. Question:**

On page 2-28 it states that Clinical Supervision must occur 3 times a month. However, on page 2-31, it states that Clinical Supervision must occur 1 time a month. Please clarify.

**Answer:**

Clinical Supervision is required three (3) times each month. See the amendment to this RFP on page 3, above.

**8. Question:**

If we had 1 team of 300 consumers could we use 1 CARE psychiatrist for 250 consumers and have 50 consumers see a community psychiatrist or would we need 1 FTE psychiatrist to see 250 consumers and a .2 FTE CARE psychiatrist to see the other 50 consumers?

**Answer:**

One psychiatrist or APRN-Rx is required for 250 consumers. Additional consumers served in excess of 250 must be receiving mental health services from a private psychiatrist or through additional staffing by the Case Management agency.

**9. Question:**

Please be specific: i.e.: "Division's approved tools for screening, assessment and reporting co-occurring data: in Section III A.i.b. Dual Diagnosis Substance Abuse Services.

**Answer:**

The DIVISION approved tools are CAGE-AID and MIDAS.

**10. Question:**

Personnel requirements include a psychiatrist. Will there still be an option for these community-based case management clients to see community MHC MD's? More importantly, will there be capacity for these clients at the CMHC's and what will be the wait times for screening?

**Answer:**

Community-based case management consumers may receive services from a private psychiatrist or CMHC psychiatrist as available. The standard wait time for initial screening at the CMHC is less than seven (7) days.

**11. Question:**

Please clarify MD: Consumer ratios?

**Answer:**

The psychiatrist or APRN-Rx to Consumer ratio is 1 to 25 0.

**12. Question:**

How does DIVISION plan to address the barriers to DBT treatment for our CM clients?

**Answer:**

DBT is beyond the scope of this RFP.

**13. Question:**

Why is there no peer review conducted prior to the clinical denial? This is not community standard.

**Answer:**

The AMHD Medical Director or physician designee makes all clinical denials.

**14. Question:**

HMSA does not require prior authorization for psychological testing. Why is Division requiring this for testing?

**Answer:**

Psychological testing is not reimbursable by this RFP.

**15. Question:**

Why is group therapy not included in the schedule for reimbursement?

**Answer:**

Group therapy is beyond the scope of services for this RFP.

**16. Question:**

We were told by Dr. Hester that the $200.00 sanction/penalty would not be enforced. Why was it included in this RFP for CM services?

**Answer:**

The DIVISION retains the option to impose sanctions as appropriate.

**17. Question:**

The ICM rate was previously lowered from $22 to $20 per unit. Why is this rate being used, when more requirements have been added to this RFP?

**Answer:**

The ICM service rate is $20.25 per fifteen (15) minutes. This service will include consumers with less acute needs than just ICM. This will balance out the requirements.

**18. Question:**

With the ACT model being required now, we expect that more activity will exist in the CM clients. Why are the CM rates not equivalent to the current ACT rates (e.g. $27.00 per unit)

**Answer:**

The ACT model is not being required for this RFP. This is an RFP for community-based case management.

**19. Question:**

Why are Quest rates being used for the MD and APRN? This population has much more risk/liability than the general population, so these rates appear to be low for the proposed CM services.

**Answer:**

The rates in the RFP are the same rates that the CMHCs are paid for SMI consumers.

**20. Question:**

Why are the criteria so vague regarding the low intensity clients who need only monthly visits?

**Answer:**

The criteria listed in this RFP are intended to serve as a general guideline and example since it would be difficult to account for all possible scenarios encountered by case managers.

**21. Question:**

Why does the provider not have the right to decline a referral? This is not community standard, and seems very hostile to providers, especially given that the CMHC's will also provide CM services.

**Answer:**

Providers may decline a referral if they are unable to meet a consumer's clinical needs. Providers must work with the DIVISION to identify alternative services.

**22. Question:**

Why are mileage billing codes not included for Oahu CM services?

**Answer:**

There is no mileage reimbursement for case management services on Oahu or neighbor islands.

**23. Question:**

Why is there now such a trend by Division to be prescribing and directing treatment for providers?

**Answer:**

It is the responsibility of the DIVISION to ensure that quality standards are defined and available to providers. The RFP process is a vehicle to do so.

**24. Question:**

Why is the RFP requiring so many UM requirements, when Division rarely generates any administrative or clinical denials? For this LOC, would it not be appropriate to eliminate all prior authorizations?

**Answer:**

UM requirements must be followed for all levels of care in order to ensure appropriate utilization, support claims payment, and support availability monitoring.

**25. Question:**

By requiring that the MD be the ultimate leader, AMHD seems to be advocating the medical model. Why has AMHD violated the community-based model by emphasizing the MD?

**Answer:**

The DIVISION's Community Plan requires a psychiatrist to have ultimate clinical responsibility for the recovery planning team. However, the case manager is responsible for the overall coordination of services.

**26. Question:**

AMHD seems to be kind of derivative, using a CCS model for these CM services. Why not use a capitation or even a case rate for reimbursement rather than a FFS methodology? How about cost-reimbursement unit?

**Answer:**

The DIVISION is not a health plan and is limited to fee-for-service rates approved by the Med-QUEST Division in order to obtain MRO reimbursement.

**27. Question:**

Some agencies pay their workers on an hourly basis rather than by salary. How does AMHD assure that difficult or complex clients do not fall in the gaps or experience underutilization of CM services?

**Answer:**

The DIVISION will employ the following measures to ensure appropriate CM utilization: site visits, annual monitoring, review of treatment records, review and processing of claims and billings, interviews with consumers, and exploration of utilization history.

**28. Question:**

The providers have expressed concerns about the definition of a QMHP. Why has Division adopted higher credentials than other states for this QMHP definition?

**Answer:**

The definition of a QMHP has been directly incorporated from the State Plan Amendment and Hawaii Administrative Rules.

**29. Question:**

What does division plan to do regarding improving provider relations?

**Answer:**

This question does not apply to this RFP.

**30. Question:**

Why are rural issues/considerations not included in this RFP?

**Answer:**

The DIVISION took into consideration the limited number of psychiatrists on neighbor islands by permitting the use of APRN-Rx.

**31. Question:**

Why are ACT terms not included in all neighbor islands? Some CM providers have felt that they actually do ACT services for CM clients on the neighbor islands. How does AMHD propose to address this common problem?

**Answer:**

This RFP only applies to CM. As such, this question does not apply.

**32. Question:**

Why are potential contracts from this RFP slanted so negatively against the provider?
**Answer:**

The DIVISION believes that this RFP has attempted to take into consideration the limitations and needs of providers and tempered them with the goal of improved continuity and efficiency of care for the consumer.

**33. Question:**

We have been asked to attend an inordinate amount of meetings and trainings, taking time away from direct service. Why not pay providers for their time in such meetings?

**Answer:**

Administrative costs, including attendance at meetings, are included in the stated rates.

**34. Question:**

There is a statement that consumer consent is not required for oversight activities of the Division and its agency. Do oversight activities include utilization management?

**Answer:**

Yes.

**35. Question:**

Based on the RFP model which seems to reflect an outpatient clinic with bilingual CM. Is there a role for a targeted case management bilingual CM that works within or alongside this type of model? Would future RFP's for bilingual case management and /or interpretation/translation service be made available?

**Answer:**

Providers interested in providing bilingual case management services should do so through this RFP. Bilingual CM staff must meet the stated qualifications in this RFP. Interpretation/translation services not provided as part of case management services are outside the scope of this RFP.

**36. Question:**

Therapy is necessary for case managers need to be able to contract with master's level or PhD level therapists to assist consumers in the recovery process. If therapy is a MRO reimbursement that is an additional benefit to the state.

**Answer:**

The current scope of this RFP does not include psychotherapy, except as provided by the psychiatrist or APRN.

**37. Question:**

What is AMHD's position on the number of CM teams being awarded a contract in a specific area as this is not stated in the RFP?

**Answer:**

The DIVISION may award multiple contracts to meet the needs of the specified target population.

Applicants may propose to serve as many geographical areas as they wish. They should describe the number of teams required to serve the proposed areas in their discussion of staffing and organization. See Question 47, below.

**38. Question:**

Clarification on single and multiple contract awards, 2-15, sub-section D. Are applicants able to submit multiple proposals for services to be provided in specific geographical areas in different counties? For example, submitting a proposal for services with maximum of three hundred (300) consumers in the Waianae/Leeward coast area in Oahu County and a second proposal for services with a maximum of two hundred (200) consumers in the Hilo area in Big Island County.

**Answer:**

The RFP does not allow multiple or alternate proposals. Applicants proposing to serve more than one area should do so in a single proposal.

**39. Question:**

Are the RN and peer specialist required for the CM team? If not, what are their required roles and responsibilities?

**Answer:**

The RN and peer specialist are required for the CM team.

**40. Question:**

Please restate the purpose of this RFP, including reasons for levels of current services (TCM/ICM) being redefined.

**Answer:**

The primary purpose of this RFP and the revision of CM services is to provide improved continuity of care and efficient services for both providers and consumers.

**41. Question:**

Why was there no opportunity presented by AMHD to the public regarding consultation concerning rule changes for case management levels? For example, ICM and TCM under this RFP being combined as CBCM? This is a historical change in services from clear case management services to a combination of case management and outpatient treatment services.

**Answer:**

Opportunity was provided for community feedback through the RFI process.

**42. Question:**

Please define any Administrative Rules that would need to be reviewed prior to the implementation of this RFP.

**Answer:**

It is the responsibility of the applicant to review all of the requirements of the RFP and research any applicable Administrative Rules. The DIVISION will clarify any questions pertaining to specific and relevant Administrative Rules.

**43. Question:**

Please address the appropriateness of this RFP including any areas in need of Administrative Rule review, technical requirement changes, and staffing or/credentialing requirements compared to the current case management contracts for ICM and TCM.

**Answer:**

The design requirements stated in the RFP are procurement specifications and do not require Administrative Rule review. The DIVISION will clarify any questions pertaining to specific and relevant Administrative Rules, technical requirement changes, and staffing or credentialing requirements.

**44. Question:**

Does this CBCM service as defined in the RFP fall under the MRO reimbursable services?

**Answer:**

Yes

**45. Question:**

Please restate the definition of QMHP, MHP and specifically define CM role and responsibilities. Under this RFP, CM will have a wider CM role, but not specifically to address therapy because therapist is different role.

**Answer:**

Case Management functions may be provided by a QMHP, MHP, or a mental health worker. Please refer to Attachment F of the RFP for the definition and qualifications of the QMHP and MHP and to Attachment M for the definition of the mental health worker. Please note the amendment on page 4 of this Addendum relating to the requirements of an RN as a Mental Health Professional.

**46. Question:**

Can applicant sub-contract with another entity to provide therapy services? What are the sub-contracting options covered under this RFP?

**Answer:**

Please refer to the sub-contracting options identified in the RFP and in the Amendments to Section 2, Service Specifications on page 3, above.

**47. Question:**

Does the MRP allow therapy reimbursement? If not, is AMHD considering pursuing this as a future option?

**Answer:**

Therapy reimbursement is limited to those types specified in the RFP to be provided by a psychiatrist or APRN-Rx.

**48. Question:**

Is there any room for negotiation between AMHD and applicant regarding consideration for a staff's time on job/direct work experience for equivalent to educational requirements for the position?

**Answer:**

Staff must meet the requirements identified in the RFP.

**49. Question:**

How is AMHD addressing the issue of excluding "qualified" CMs from performing CM duties because of lacking education requirements set by AMHD? The decision to change the definition of a CM is not meeting the needs for consumers and this is a concern.

**Answer:**

Case managers are required to meet the education and experience requirements set forth in the RFP.

**50. Question:**

Therapy services are not well defined in this RFP. Please provide more explanation on reasons for why psychologist/therapist/therapy are excluded from this RFP (versus inclusion of psychiatrist/APRN-Rx and RN and peer specialist).

**Answer:**

Community-based case management is the focus of this RFP. Since a psychiatrist is a required member of the CM team, the DIVISION will reimburse the CM psychiatrist or APRN-RX to promote continuity of care for the consumer.

**51. Question:**

Is MRO Certification required for this program? (page 2-13)

**Answer:**

Yes.

**52. Question:**

Is a Peer Specialist required? If so, do they bill under case management services? (page 2-30)

**Answer:**

A Peer Specialist is required. Billing codes will be provided through a future amendment to this RFP.

**53. Question:**

Are there a minimum number of consumers required for a team? (page 2-26)

**Answer:**

No.

**54. Question:**

Are nursing services provided by the RN billed under case management services? (i.e. medication administration, wound care, immunizations, etc.)
(pages 2-29, 2-30)

**Answer:**

Reimbursement for wound care and immunizations are not included in the scope of this RFP. A RN can use the billable codes identified in this RFP for therapeutic injection or other appropriate billable codes for case management services if the RN meets the minimum requirements of a case manager.

**55. Question:**

Are psychologists and LCSWs eligible to bill for services under this program, or is the program restricted to psychiatrists and APRN – Behavioral Health? (page 2-39)

**Answer:**

Psychologists and LCSWs who meet the qualifications for, and serve as, the Team Leader or Case Manager may bill for services appropriate to those positions.

**56. Question:**

Can clinical supervision be provided by an administrative QMHP who is already on our staff (so the Team Leader can spend more time providing billable services.)? (page 2-28)

**Answer:**

Yes.

**57. Question:**

Can we bill AMHD for time spent with registered consumers who are <u>not</u> part of this team? For example, ICM consumers living at Safe Haven under AMHD funded beds receive services from our in-house case managers in addition to their assigned ICM case manager. Can we bill for those units if we are awarded this contract?

**Answer:**

Consumers eligible for DIVISION services will be assigned to one Case Management provider who will be the only authorized case management provider for the purposes of reimbursement.

**58. Question:**

Can the Psychiatrist on the team determine the Level of Care for consumers who have not yet been assessed by AMHD (as opposed to the AMHD Assessor)? (page 2-17)

**Answer:**

No.

**59. Question:**

Is it assumed that a CM Case Assessment is completed only one (1) time per consumer, and therefore can only be billed for once? (page 2-18 and 2-38)

**Answer:**

An initial assessment is completed only once within the time frame specified on page 2-18. However, Recovery Plan review is required and detailed in Attachment L of the RFP. The appropriate codes listed on page 2-38 should be used.

**60. Question:**

Is there a requirement for how many times the Treatment Plan (IRP) needs to be updated annually? If the requirement is more than one (1) time per year, can we bill accordingly for CM Treatment Planning? (page 2-18 and 2-38)

**Answer:**

Please refer to Attachment L of the RFP that details the AMHD Policy and Procedure regarding Recovery Treatment Planning.

**61. Question:**

Reference 2.I.C.1 Can a Peer Specialist bill for codes in Section 2 3. B. 10. (p. 2-38)? If not, how does DIVISION plan to reimburse PROVIDER for services delivered by the Peers?

**Answer:**

The billing codes for peer specialist will be provided in a future amendment to the RFP.

**62. Question:**

Reference 2.III.3.11.d what does it mean to provide services from "7:30 AM to 9:00 PM?" Note that CM services are provided 24 hours/ day 365 days / year, and, as stipulated at 2.III.A.11.a.5 (p. 2-26), there are no "office hours" because consumers are served in the community rather than at an office.

**Answer:**

Service hours shall be based on consumer needs. Therefore, while not all consumers will require services spanning this time duration, regular services should be available from the hours of 7:30 a.m. to 9:00 p.m. Crisis services should be available 24 hours a day, 365 days a year.

**63. Question:**

Reference 2.III.A.11.d p. 2-28) & 2.III.B.1 (page 2.31) It appears that bullet "i" on p. 2-31 does not match with section "d" in relation to minimum required supervision. Please clarify.

**Answer:**

Clinical supervision is required three (3) times per month.

**64. Question:**

Reference 2.III.B.1.e (p. 2-30) There is a shortage of Peer Specialists who are certified by DIVISION. Is it possible to fulfill this requirement with a Peer Specialist who does not have the AMHD Certification?

**Answer:**

No. The applicant's proposal should include the agency's plan for recruitment of peer specialists.

**65. Question:**

Does AMHD have a preference about psychiatrists being employees of the PROVIDER and paid at a rate set by the PROVIDER, or are psychiatrists independent contractors who bill AMHD at the rates indicated at paragraph B.10 (p. 2-39)

**Answer:**

The DIVISION will contract with the case management agency for case management services and limited psychiatric services as defined in this RFP. Therefore, only the case management agency contracted with the DIVISION can bill for these services.

**66. Question:**

Reference Page 1-11, XX_. What are the specific metrics by which the performance of the PROVIDER shall be judged under each of the five criteria listed?

**Answer:**

Provider performance measures are defined on an annual basis and include provider monitoring and reporting.

**67. Question:**

Please confirm the fidelity scales developed by the DIVISION and the specific services to which they apply.

**Answer:**

The DIVISION has no fidelity scales developed for CM at this time.

**68. Question:**

Are PROVIDERS allowed to submit a bill more than once per month?

**Answer:**

Providers may invoice twice a month.

**69. Question:**

What is a reasonable time period that a PROVIDER may expect to get paid after a claim is submitted to AMHD?

**Answer:**

If a clean claim is submitted and funds are available, the DIVISION's goal is to make payment within 30 calendar days of the submission date.

**70. Question:**

We note that there is no longer a requirement that the team leader or RN assume a caseload. Is this accurate? A good change as the supervision and nursing responsibilities mitigate against assuming a caseload.

**Answer:**

A caseload is not required for the team leader, however, the ratio for RN to consumer is 1:150.

**71. Question:**

It appears that there is no longer any distinction between ICM and TCM. We are simply providing case management services. Is this correct?

**Answer:**

Yes.

**72. Question:**

On page 3-2, Section B, it states that applicant shall provide a description of projects/contacts, including references, pertinent to the proposed services. Please explain what type of references you are seeking and who might provide these?

**Answer:**

References should be able to attest to the applicant's ability to provide the services described in the RFP and to meet the program and administrative requirements stated in the RFP.

**73. Question:**

It appears that a peer specialist is optional, rather than required. Is this accurate?

**Answer:**

No. A peer specialist is required.

**74. Question:**

On page 2-18, it states that we will have "a plan to manage its waiting list." When we reach maximum capacity, we would refer to AMHD's UM for placement with another provider. It is not clinically appropriate to place someone on a wait list who requires case management services. How does the Division propose to handle consumers when a program has reached capacity and what justification is there for placing SPMI consumers who require care on a wait list?

**Answer:**

The DIVISION will manage all waitlists for referrals to CBCM services. See the amendment to this RFP on page 3, above.

**75. Question:**

The RFP mentions transportation; can we get clarification regarding what is expected? We do not allow staff to transport consumers in their personal vehicles. We do provide bus passes. Is this sufficient?

**Answer:**

The case management agency must arrange for the most appropriate mode of transportation necessary to ensure the safety of the consumer and the community.

**76. Question:**

Section 1: page 1-1, item I. Contract start date: 11/1/2006. How will the potential conflict of interest be addressed with the overlap of programs currently falling under DHS?

**Answer:**

This RFP is unrelated to DHS programs.

**77. Question:**

Section 2: page 2-4, item E, paragraph 2:
Confirming it is acceptable to submit one proposal for more than one island including but not limited to more than one geographical area on one island? I.e. Leeward and Windward sides of Oahu

**Answer:**

Yes. Applicants should submit one proposal identifying every island, or specific geographical area on an island, that they propose to serve.

**78. Question:**

Section 2: page 2-9, item 10c, paragraph 1: How will eligibility and enrollment notifications be distributed to providers? How soon upon determination of eligibility will provider be notified? How often will updates be distributed?

**Answer:**

Assessment staff will assign a CM or ACT team upon eligibility determination. Providers will then receive an authorization. Initial authorizations are generally processed within forty-eight (48) working hours of the eligibility determination. There are no updates as consumers generally maintain eligibility.

**79. Question:**

Section 2: page 2-12, item j, paragraph 1:
As noted in this section, a small population of the SMI s are being provided by the behavioral health carve-out program contracted by MQD.
Will the members in this carve-out program remain with the existing program for continuity of care purposes? If not, what kind of transition plan is in place to transition existing members enrolled in this program to their new provider to ensure continuity of care?

**Answer:**

If an award is made to the MQD behavioral health carve-out program, consumers receiving services from them will be given the opportunity to continue receiving services from them. If consumers would like the opportunity to change to another DIVISION funded agency, they will be given that opportunity. All DIVISION consumers have the right to select their provider based on availability.

**80. Question:**

Section 2: page 2-13, item l, paragraph 1:
It appears all services are to be billed on a fee-for-service basis. Under what circumstance would an encounter claim need to be processed?

**Answer:**

Since all services are billed fee-for-service, an encounter claim is not applicable.

**81. Question:**

Section 2: page 2-1, item d:
Will the provider manual be distributed?

**Answer:**

The provider manual is posted on the DIVISION website at www.amhd.org.

**82. Question:**

Section 2: page 2-19, paragraph 2:
Many of consumers already receive services from the private providers. How are/will the current providers included in this IRP process?

**Answer:**

Case Management agencies should invite all providers of services to the IRP meetings.

**83. Question:**

Section 2: page 2-20, number 8, a.2:
It appears the structure being described is a clinic setting which includes medication administration. How is this in line with a case management program? Often, the role of a case manager is to refer clients to a private provider of their choice for these services?

**Answer:**

Consumers may choose to receive any of these services from a private provider.

**84. Question:**

Section 2: page 2-21, number b.3:
How does this affect the clients that are already seen by a private provider?

**Answer:**

Consumers currently being seen by a private provider may continue to obtain services from a private provider.

**85. Question:**

Section 2: page 2-24, number g.4:
Will DIVISION ensure adequate training resources be made available?

**Answer:**

The DIVISION provides periodic training sessions, develops and distributes training materials and resource guides, and provides technical assistance and consultation to provider organizations upon request.

**86. Question:**

Section 2: pg 2-25, number 10, paragraph 2:
The description here is one typically associated with a clinic similar to the current MH division. How does this affect the clients who are already being seen by the private providers in the community?

**Answer:**

Consumers who are currently seen by a private provider may continue to receive services from a private provider.

**87. Question:**

Section 2., pg. 2-26, number 11, a. 2:
Ratio shall not exceed 1:30 with the majority of the consumers being relatively stable and in active stages of recovery. If you are working with higher acuity consumers particularly the dual diagnosed clients, or ACT clients, the ratio should be much lower to ensure appropriate care. Is this contract intended to only service the targeted population, or does this include ACT and ICM level of clients as well?

**Answer:**

This RFP is intended to serve consumers meeting the DIVISION criteria for case management. ACT is not a case management service.

**88. Question:**

Section 2, pg. 2-26, number 11, a. 3:
Would this ratio be the same if the clients were seeing private providers?

**Answer:**

The ratio for consumers to psychiatrist remains the same.

**89. Question:**

Section 2, pg. 2-26, number 11, a. 4:
What is the definition/qualification of a peer specialist?

**Answer:**

The peer specialist shall have, at minimum, a high school diploma, one year in recovery, and be certified as a peer specialist by the DIVISION.

**90. Question:**

Section 2, pg. 2-27, paragraph 2:
It appears that there should be some guidelines to determine the level of care that the clients will need, and for how long they would need this particular level of care.
**Answer:**

The level of care and the duration for which a consumer remains at that level of care is determined by a combination of LOCUS score, individual assessment, and the recovery plan.

**91. Question:**

Section 2, pg 2-29, item 1c:
Why would you need an RN for more than 60 clients? If the medical needs are a concern, shouldn't the CM work collaboratively with the PCP s to ensure the client gets the proper care? How was the 60 threshold determined?

**Answer:**

Case Managers may be unable to identify medical needs of consumers with co-morbid conditions. An APRN was consulted regarding the caseload.

**92. Question:**

Section 2, pg 2-32, item 2e, paragraph 1 3:
What kind of transition plan and coordination is currently underway so all parties listed are involved and working together to ensure a smooth transition?

**Answer:**

When a consumer is referred to a CM agency, the CM agency is responsible for contacting current providers of service to collaborate on a transition plan.

**93. Question:**

Section 2, pg 2-33, item 2f, paragraph 1:
Why is it necessary to submit a rate schedule when it appears all services rendered are to be on a fee-for-service basis with established rates?

**Answer:**

Applicants are required to submit budget forms detailing personnel and other operating costs in order to document that there is sufficient operating capacity to provide the services proposed.

**94. Question:**

Section 2, pg. 2-38:
There doesn't appear to be a rate for groups. What code will be used for groups and family meetings? What is the rate?

**Answer:**

Please refer to psychiatrist/APRN-RX group and family rates identified in this RFP.

**95. Question:**

Section 5, Attachment F, pg. 1, under the QMHP section:
Can we grandfather the current LSW s who function as Team Leader s into the QMHP positions?

**Answer:**

QMHP requirements as specified in this RFP must be met.

**96. Question:**

Section 5, Attachment F, pg. 1, under the MHP section:
Can we grandfather the LPN s that function as Team Leaders into the MHP positions?

**Answer:**
MHP requirements as specified in this RFP must be met.

**97. Question:**

Section 5, Attachment M:
There are many qualified care managers who do not hold a bachelor's degree. These CMs are skilled, experienced, and well trained in working with the SMI/dual diagnosed clients. If a CM is currently employed in such a position, is it possible to grandfather these CM s into the Mental Health Worker position?

**Answer:**

All staff must meet the requirements set forth in the RFP.

**98. Question:**

What was the process undertaken by AMHD in collecting and considering the responses to the RFI issued relevant to Community-Based Case Management?

**Answer:**

The DIVISION published an RFI in February, 2006 seeking input regarding community-based case management Services. A total of six organizations responded to the RFI. Of these, four were currently providing services under contracts with the DIVISION. Responses were reviewed by DIVISION staff to determine if this input should be included in the RFP.

**99. Question:**

Who were the individuals or team of individuals who reviewed the answers or responses to the RFI?

**Answer:**

The responses to the RFI were reviewed by appropriate DIVISION staff.

**100. Question:**

What process was taken in considering the responses to the RFI and what impact or influence did the responses have in the design of the RFP?

**Answer:**

See Question 114, above. The RFI responses were carefully reviewed by DIVISION staff, in conjunction with service requirements of the Community Plan, SAMHSA EBT Toolkits, Hawaii Administrative Rules, and MRO requirements to determine the final design.

**101. Question:**

Are there any meeting notes or minutes taken reflecting on the consideration given to the RFI in designing the RFP?

**Answer:**

No.

**102. Question:**

How did the Department of Health ensure community involvement in determining the service delivery arrangements appropriate to the Wai`anae community as required by Chapter 334, HRS? Were there meetings in the community?

**Answer:**

Community involvement is assured through the Service Area Board's input into the DIVISION's CISAP and the Statewide Comprehensive Integrated Service Plan.

**103. Question:**

Has the Department of Health established a service area center to be the focal point in the development of community-based case management for the Wai`anae community as required by Chapter 334, HRS?

**Answer:**

The Department of Health is not required to establish a service area center per amendments to 334-11, HRS.

**104. Question:**

Please identify the service area board member(s) representing the Wai`anae community.

**Answer:**

The service area board has been unable to solicit representation from the Wai'anae community despite numerous requests.

**105. Question:**

Please provide any minutes of the service area board relevant to the provision of community-based case management services over the past year.

**Answer:**

Minutes of the service area board meetings are public record and copies can be obtained through the Oahu Service Area Administrator.

**106. Question:**

The RFP at page 2-2 identify planning activities conducted in preparation for this RFP. No mention is made of the involvement of the service area board s involvement. Was there involvement by the service area board in the development of this RFP?

**Answer:**

Yes.

**107. Question:**

Hawaii Administrative Rules Sec. 11-175-16(a) Community-based planning calls for Each service area center in conjunction with its service area board shall seek information, opinions, and recommendations from service area residents through such measures as community forums, public meetings, formal and informal surveys. Please inform me of the information, opinions and recommendations made from service area residents, citing documentations reflecting notes, minutes or other records of community forums, public meetings, formal and informal surveys relative to community-based case management services contained in the RFP under discussion.

**Answer:**

A service area center is not required. Information was gathered through Service Area Board meetings, the Statewide Mental Health Council, and the RFI process.

**108. Question:**

At page 2-18 of the RFP, 5. b., the applicant is required to provide a service of initial face-to-face intake contact with each consumer within 24 hours of referral. What is the fee to be charged for this service as it is not noted in the fee schedule on page 2-38 and 2-39 of the RFP? Who is the person able to perform this intake contact?

**Answer:**

There is no separate billing code specific to initial, face to face contact. Providers should use the appropriate code and bill according to the Fee Schedule provided with the RFP.

**109. Question:**

At page 2-18, 5. d. the provider is expected to provide each consumer with a single, individualized, coordinated master recovery plan.

a. How will this service be paid for?
b. Who specifically will be charged with writing up the IRP?
c. How will the members of the treatment team be paid for services in assisting in the development of the recovery plan?
d. Will the Division prepare billing codes for this service?

**Answer:**

a. See treatment planning billing codes
b. The team is charged with writing the IRP.
c. When the team is conducting recovery planning meetings, only one member of the case management team can bill for this process.
d. Please refer to the RFP for billing codes.

**110. Question:**

Under the same subject but at page 2-19, the case manager is charged with coordinating the development of and monitoring the implementation of the IRP and shall act as the communications liaison for the CM team both internally and externally. Please identify the billing code under which the case manager will be paid for this service.

**Answer:**

There is no separate billing code.

**111. Question:**

At page 2-19, 6. Outreach, Partnering of CM team members shall be utilized as an option to engage consumers. How will the partnering members be paid for their individual service, i.e., a case manager and a nurse meets with a consumer, will both of these partners be able to bill for the same time and for the same interaction with the consumer?

**Answer:**

Only one partner may bill.

**112. Question:**

At page 2-20 7.c. the program is required to ensure that crisis services shall be provided twenty-four (24) hours per day, seven (7) days per week. Does this mean that the current crisis services such as crisis mobile outreach will not be available to the consumers who are serviced by the community-based case management services? What is the parting line between CMO and CBCM?

**Answer:**

Current crisis services will continue to be available. Case Management agencies are required to be available to respond to consumers in crisis twenty-four (24) hours per day, seven (7) days per week. CMO is a distinct and separate service from case management. It is expected that the CMO team will be dispatched to a scene in addition to, not instead of, the case manager when CMO services are needed.

**113. Question:**

At page 2-20, medication administration is called for in addition to education to the consumer. For these services, what are the appropriate charge codes, amounts of reimbursement and who the appropriate service providers? How does medication administration differ from medication management and medication monitoring?

**Answer:**

Medication administration refers to the physical administration of a therapeutic agent, such as through injection. This can be only completed by the appropriately licensed clinical staff and billed as a therapeutic injection. Medication management involves the clinical oversight, intervention, and prescriptive authority of a psychiatrist or APRN-Rx, while medication monitoring may involve non-clinical inquiry and follow-up with the consumer.

**114. Question:**

At page 2-20, psychoeducation is called for. For this service, what is the appropriate charge code, amounts of reimbursement and who are the appropriate service providers?

**Answer:**

Psychoeducation can be provided by an RN, case manager, Team Leader, or MD/APRN. This should be billed under case management services.

**115. Question:**

At page 2-21, Dual Diagnosis Substance Abuse Services is addressed. How does DDC-MH service differ from MI/SA service? Is a CSAC required to be on the case management team?

**Answer:**

MI/SA service is consultative and not intended for the provision of services. A CSAC is not required to be on the case management team.

**116. Question:**

In providing the basic substance abuse identification and treatment service called for at paragraph b., page 2-21, what will be the billable code under which the practitioner will be reimbursed?

**Answer:**

Basic substance abuse identification falls within the scope of general case management assessment and services and may be billed according to the Fee Schedule listed in the RFP.

**117. Question:**

At page 2-25, 9. c. the case manager is required to advocate on behalf of the consumer, for services that are accessible, . . . Under what billable code shall the case manager bill? H2015 U3?

**Answer:**

Yes, H 2015 U3.

**118. Question:**

The RFP calls for extensive involvement of an RN who will be expected to provide medication review and administration services, and work with the consumers and their support system. At page 2-29, the RN is required to provide medical assessments, basic health care, education, coordination of medical needs, and psychotropic and medical medication administration. The RN s ratio to consumers is 1 to 150. Yet, the RFP provide no avenue for the RN to be paid a fee for their services. Will the Division consider billable codes for the RN s services?

**Answer:**

With the exception of Therapeutic Injection, there are no billing codes specific to RNs listed in the RFP. A registered nurse may bill for any services identified under case management services if the RN meets the minimum qualifications of a case manager.

**119. Question:**

The RFP calls for extensive involvement of a certified Peer Support Specialist. However, it fails to address the fee or reimbursement rate for this specialist. Is this an oversight by the Division? How will the Division reimburse the provider for this service?

**Answer:**

Billing codes for peer specialists will be published in a future amendment to this RFP.

**120. Question:**

At page 2-27, consumers who have had stability as measured by no recent hospitalization or emergency room visit are to be seen once per month. What constitutes a recent hospital visit? Once within the last week, month, quarter, year?

**Answer:**

Recent hospitalization is only one of the possible variables that should be factored into determination of a consumers stability. As a general guide, 90 days or less may be considered a recent hospitalization.

**121. Question:**

At page 2-27, b. 2) crisis and emergency services are to be provided. If more than one member of a team is required to respond to a crisis, will all of the team members who responded be reimbursed for their service?

**Answer:**

The RFP does not require more than one member of a team to respond to a crisis. Only one team member can bill for the response to a crisis.

**122. Question:**

At page 2-28, CM team members are required to meet at least two times per week for case reviews. How will these CM team members be paid for this service? Will all of them be authorized to bill? What code will the Case Manager bill under? What code will the Psychiatrist bill? What code will be used by the psychologist, the nurse, the peer support specialist?

**Answer**:

The CM team may bill for time spent conducting treatment planning with a specific consumer. Only one team member may bill for this service. Case review team meetings conducted for the purpose of internal quality management are not billable under this RFP.

**123. Question:**

When other providers attend the team meetings, how are they reimbursed?

**Answer:**

The reimbursement of providers outside the case management team is outside the scope of this RFP.

**124. Question:**

At page 2-29, under management requirements, 1. b. it is stated, In geographic areas with a demonstrated shortage of qualified psychiatrist, an APRN-Rx may assume clinical leadership and responsibility. Is the Wai`anae area considered a geographic area with a demonstrated shortage of qualified psychiatrist?

**Answer:**

A Waianae provider indicated in the RFI process and for previous RFPs that psychiatric services could be provided without difficulty.

**125. Question:**

Under that same paragraph, a psychiatrist or APRN-Rx shall also be available twenty-four hours per day, seven days per week for psychiatric crises and emergencies. How will the psychiatrist or APRN-Rx be reimbursed for being on-call for these 24 hours days, seven days per week?

**Answer:**

The psychiatrist or APRN-Rx may bill for services only if they respond to a crisis.

**126. Question:**

At page 2-29, the RN is expected to play an active role in providing case management and rehabilitation services. There are four specific services listed at pages 2-29 and 2-30. But I can find no billable codes. What will the RN be able to bill under? Can these services, which appear to be appropriate for group services, be done in groups? At what rates?

**Answer:**

A registered nurse may bill for the appropriate level of service for a position in the team for which he/she is assuming and has appropriate State licensure. The billable rate would correspond to the type of service being provided. A registered nurse may bill for case management services if the RN meets the minimum qualifications of a case manager.

**127. Question:**

Does AMHD have a model disaster preparedness plan?

**Answer:**
The DIVISION's disaster preparedness plan applies to the Department of Health and DIVISION activities only.

**128. Question:**

The RFP references fidelity scales that AMHD has for the best practices noted in the Appendix...can applicant s get a copy of these fidelity scales?

**Answer:**

Attachment K provides the AMHD Policy and Procedure regarding continuity of care, which was adopted from the transition guidelines and outcome indicators established by the AACP.

**129. Question:**

There does not seem to be a requirement that each consumer must see the agency's psychiatrist. This is a positive move as many consumers have a psychiatrist they prefer to see. The agency's psychiatrist will provide psychiatric services for those consumers who do not already have an established relationship with a community psychiatrist, plus provide some of the clinical supervision and review of plans. Is this a correct interpretation?

**Answer:**

The agency's psychiatrist may provide psychiatric services for those consumers who do not already have an established relationship with a community psychiatrist or who choose to switch from another psychiatrist to receive psychiatric service from the agency psychiatrist. Active psychiatrist participation is required in recovery planning with the consumer as a part of the case management team.

**130. Question:**

On what basis did AMHD calculate the reimbursement rates? Was this rate discussed with providers? Is the rate realistic given staffing requirements?

**Answer:**

These rates were discussed with providers when initially established.

**131. Question:**

Is the definition of this community-based case management RFP services supported and/or outlined in the Community-Based Plan?

**Answer:**

The CM model, as described in the RFP, is supported by the Community Plan.